

Registration District No. **299**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution **K.C. General Hospital No. 1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **18 days**
(Specify whether
In this community **30 Years**
years, months or days)

3. (a) PRINTED FULL NAME **Mrs. Olive May Deel**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **None**

4. Sex **Female** race **White** 5. Color or 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Mr. Elmer E. Deel** 6. (c) Age of husband or wife if alive **74** years
7. Birth date of deceased **May 1 1863**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
77 8 10 hr. min.

9. Birthplace **Indiana**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business **-----**

MOTHER FATHER { 12. Name **Isaac Hurst**
13. Birthplace **Unknown**
(City, town, or county) (State or foreign country)
14. Maiden name **Sarah Thornberry**
15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **E. E. Deel**
(b) Address **3510 Campbell St**

17. (a) **Cremation** (b) Date thereof **Jan. 13, 1941**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place of burial or cremation **D.W. Newcomer's Sons**

18. (a) Signature of funeral director **D.W. Newcomer's Sons**

(b) Address **1401 Brush Creek Blvd.**

19. (a) **Jan 13 1941** (b) **M. M. Brown**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **3510 Campbell**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? **-----** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan.** day **11th**
year **1941** hour **5** minute **10 A.M.** M.

21. I hereby certify that I attended the deceased from **12-24-40**, 19__, to **1-11-41**, 19__;
that I last saw him/her alive on **1-11-41**, 19__;
and that death occurred on the date and hour stated above.

Immediate cause of death **Probable Coronary occlusion**

Due to **940**
Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy **None**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? (Specify type of place) (c) Means of injury

23. Signature **Dr. K.C. General Hospital** (M. D. or other)
Address **Med. Dir. K.C. General Hospital** Date signed

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Emile M. Calhoun

Licensed Embalmer No. *3506*

P. O. Address *K. C. Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.